NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

MH/DD/SAS Community Systems Progress Indicators

Report for Third Quarter SFY 2006-2007

January 1 – March 31, 2007

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May 31, 2007

Quality
NC DMH/DD/SAS

*What we are witnessing today is a shift toward holding **human service systems** accountable for the benefits (or lack thereof) at the consumer level. …With [this] shift, measures have broadened and have begun to focus on consumer outcomes that are related to specific provider organizations and practitioners. Outcomes measures themselves are undergoing modification with less emphasis on diagnoses and symptoms and greater emphasis on recovery and resilience. The view of "the consumer" also is undergoing change with less emphasis on the individual and greater emphasis on the functional ecology of the individual (e.g. family, friends, neighborhood, community).*

…

Obviously, the transformation process calls for sustained leadership and will result in new roles in state systems and bureaucracies. Decision support data systems are essential to the entire process, so decisions can be made on the basis of better and better outcomes for children, families, and adults. Form will follow function. We cannot have new (better) outcomes by doing the same old thing. We need to go into the transformation process with clear purpose, a thoughtful approach, and excellent sources of data related to the overall mission and goals of the system being transformed. We need to expect and plan for organizational and system change. With practice, we can learn how to initiate and manage change effectively, we can learn how to implement innovations to achieve maximum benefits for consumers, and we can develop new services system infrastructures specifically designed to support excellence as practitioners work with consumers. With practice, our approach to transformation will be come well entrenched and the benefits to consumers will improve with each generation.

FromThe ImpleNet Quarterly e-Newsletter, National Implementation Research Network, Louis de la Parte Florida Mental Health Institute, University of South Florida. October 2006.

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Introduction

Effective management of community systems is essential for the success of North Carolina's efforts to transform its mental health/developmental disabilities/substance abuse service (MH/DD/SAS) system. Tracking the status and progress of community systems provides a means for the public and General Assembly to hold the Division of MH/DD/SAS and the Local Management Entities (LMEs) accountable for progress toward the goals of the system reform. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.

The following pages constitute the third report in the SFY 2006-2007 series on local progress indicators.[1] These indicators measure each local system's progress in three areas:

- Service Delivery
- Service Quality
- System Management

Within each of these areas, the Division has selected indicators to gauge problems and progress on reform goals. Each area covered by these indicators involves substantial "behind-the-scenes" activity by service providers, LME and state government staff, consumers, and family members. These indicators do not purport to cover all of those efforts. Instead, they provide critical highlights that can guide analysis by the public, the General Assembly, and local and state managers into more detailed issues that affect progress toward the goals of MH/DD/SAS system transformation. The indicators were chosen to reflect:

- Accepted standards of care
- Fair and reliable measures
- Readily available data sources.

These items, along with the rationales for their use, are presented in Table 1 below.

[1] This report fulfills the requirements of S.L. 2006-142 (HB 2077) that directs the Department of Health and Human Services to develop critical indicators of LME performance. Measures reflect the goals of the NC State Plans 2000-2006, the President's New Freedom Initiative, CMS' Quality Framework for Home and Community Based Services, and SAMHSA's Federal Action Agenda and National Outcome Measures.

Table 1: Rationale for Progress Indicators

Progress Area	Indicator	Rationale
Service Delivery	1. Services to Persons In Need (Treated Prevalence)[2]	NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance.
	2. Timely initiation and engagement in service	Best practice for initiating and continuing care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.
	3. Effective use of state psychiatric hospitals	State psychiatric hospitals provide a safety net for the community service system. An adequate community system can and should provide their residents with crisis services and short-term inpatient care close to home. This helps families stay in touch and reserves high-cost state facility beds for consumers with long-term care needs. Reducing the short-term use of state psychiatric hospitals is a goal that also allows more effective and efficient use of funds for community services.
	4. Timely follow-up after inpatient care	Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community supports. A community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[3]
Service Quality	5. Consumer choice of service providers	A system that offers consumers an array of providers supports the development of successful practitioner-consumer relationships which, in turn, foster recovery and stability. Consumer choice can also improve the quality of the entire service system, as providers strive to satisfy consumers.

[2] *Prevalence* is defined as the percent of the population estimated to have a particular condition within a given year. *Treated prevalence* is the percent of the population in need who receive services for that condition within a year.

[3] Health Plan Employer Data and Information Set (HEDIS®) measure.

Progress Area	Indicator	Rationale
	6. Use of evidence-based service models and best practices	Quality care is care that makes a real difference in an individual's life. Service models and practices that have been tested for effectiveness provide the greatest opportunity for individuals to attain stability in their lives. NC is promoting adoption of evidence-based practices in community service systems.
System Management	7. Involvement of consumers and family members in the local system	The vibrancy of the local Consumer and Family Advisory Committees (CFACs) provides an indication of the responsiveness of the local system and its effectiveness in meeting the needs of residents and consumers. An engaged CFAC membership, with balanced representation across disabilities, is necessary for the LME to hear and respond to the needs of its community.
	8. Effective management of service funds	Stretching limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.
	9. Effective management of information	Efficient flow of information is vital for effective decision making and oversight of a complex service system. Timely submission of consumer information is a gauge of the management and coordination capacity of the local system and the technological resources available to support it.

The following pages present graphs showing the progress of each LME on these nine selected indicators for the most recent time period available. Measures relying on service claims data are delayed by 90 to 180 days to allow time for claims to be processed. The source information below each graph provides details on the data systems and time periods used.

For the progress area, Service Quality, LMEs are grouped according to their population density. The resulting categories – Urban, Mixed, and Rural – group LMEs that face similar challenges (e.g. transportation, number in need of intensive services).[4]

Tables showing the statistics for each LME on the indicators are available in a separate document, the *Appendices for MH/DD/SAS Community Systems Progress Indicators.*[5] Both are available on the Division website at:

http://www.ncdhhs.gov/mhddsas/statspublications/reports

[4] The data used to group LMEs into categories is available in Appendix B.

[5] A list of counties that make up each LME is available in the Report Appendix.

This third report includes measures for which valid indicators and dependable data have previously been developed. The Division is currently working with consultants to develop additional measures for the SFY 2007-2008 series of reports, including measures of:

- Timely consumer access to emergent, urgent and routine services
- Readmissions to state psychiatric hospitals and alcohol and drug abuse treatment centers (ADATCs)
- Use of residential services for children
- Local oversight of services delivered by private provider agencies
- Timely response to consumer complaints.

The information in this report complements the Quarterly DHHS-LME Performance Contract Reports, which evaluate each LME's compliance with 30 contractual items. *Indicator 4: Timely Follow-up Care after Inpatient Care* in Table 1 above is replacing the measure previously used in the Performance Contract Reports. The data for *Indicator 9: Effective Management of Information* will continue to appear in both reports.

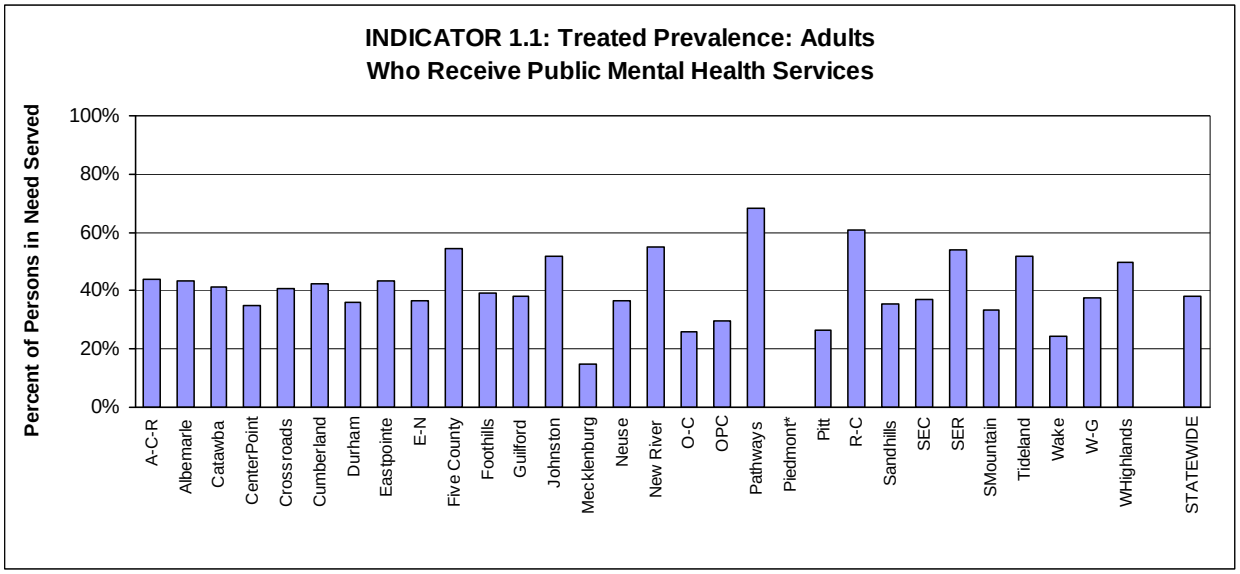
In SFY 2007-2008 the Division will redesign and merge the current Community Systems Progress Indicators Report and the Quarterly DHHS-LME Performance Contract Report. This change is intended to reflect the system's increasing focus on improving service access, availability, appropriateness, quality and effectiveness, while continuing to track adherence to the fundamental elements of good system management.

Service Delivery

Indicator 1: Services to Persons in Need

1.1 Adult Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. January 1, 2006 - December 31, 2006; N=334,736 adults in need

Almost 55 out of every 1,000 adults (5.40%) in North Carolina experience a severe or severe and persistent mental illness (SMI or SPMI) in any given year.[6] Statewide, 126,864 adults (38% of those in need of services) received federal or state funded MH services through our community service system from January through December 2006.[7] The rate of adults who were served varied among LMEs from a low of 15% (Mecklenburg) to a high of 68% (Pathways).

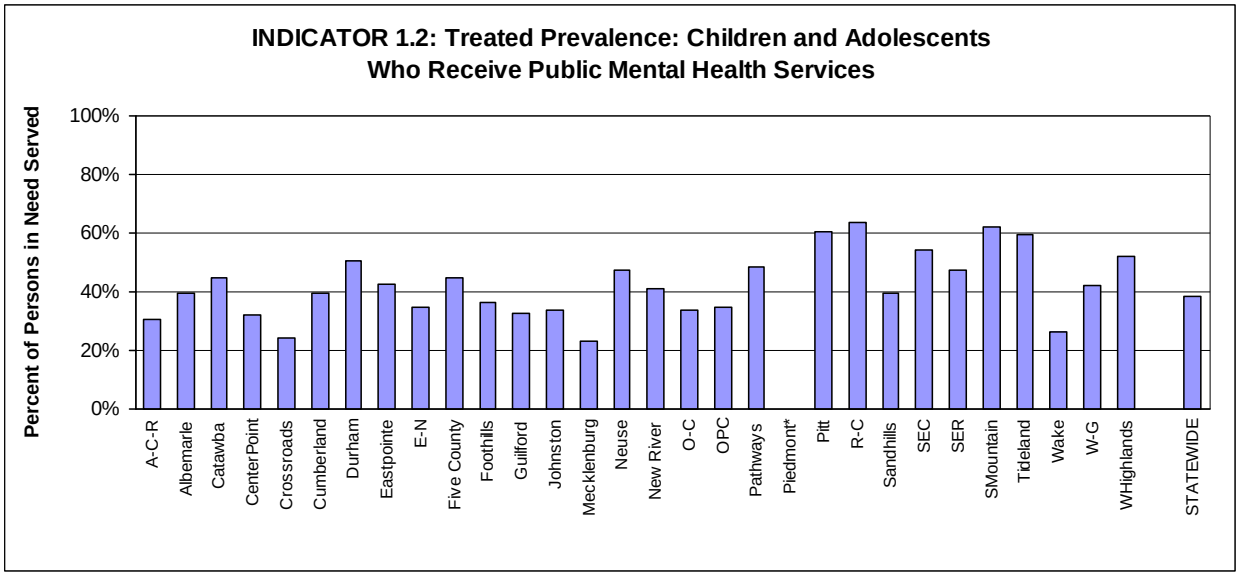
** Data on service claims for Piedmont are not available for this report.*

[6] URS Table 1: Number of Persons with Serious Mental Illness [*sic*], age 18 and older, by State, 2005, Midpoint of range between lower and upper limits of estimate. Prepared by NRI/SDICC for CMHS: August 29, 2006. Estimates adjusted to North Carolina population.

[7] The numbers served reflect adults, ages 18 and over, who received any MH services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private funds.

Indicator 1: Services to Persons in Need
1.2 Child and Adolescent Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. January 1, 2006 - December 31, 2006; N=196,447 children and adolescents in need

In North Carolina, 120 out of every 1,000 children and adolescents (12.00%) experience severe emotional disturbances (SED) in any given year.[8] Statewide, 75,184 children and adolescents (38% of those in need of services) received federal or state funded MH services through our community service system from January through December 2006.[9] The rate of those served varied from a low of 23% (Mecklenburg) to a high of 64% (Roanoke-Chowan).

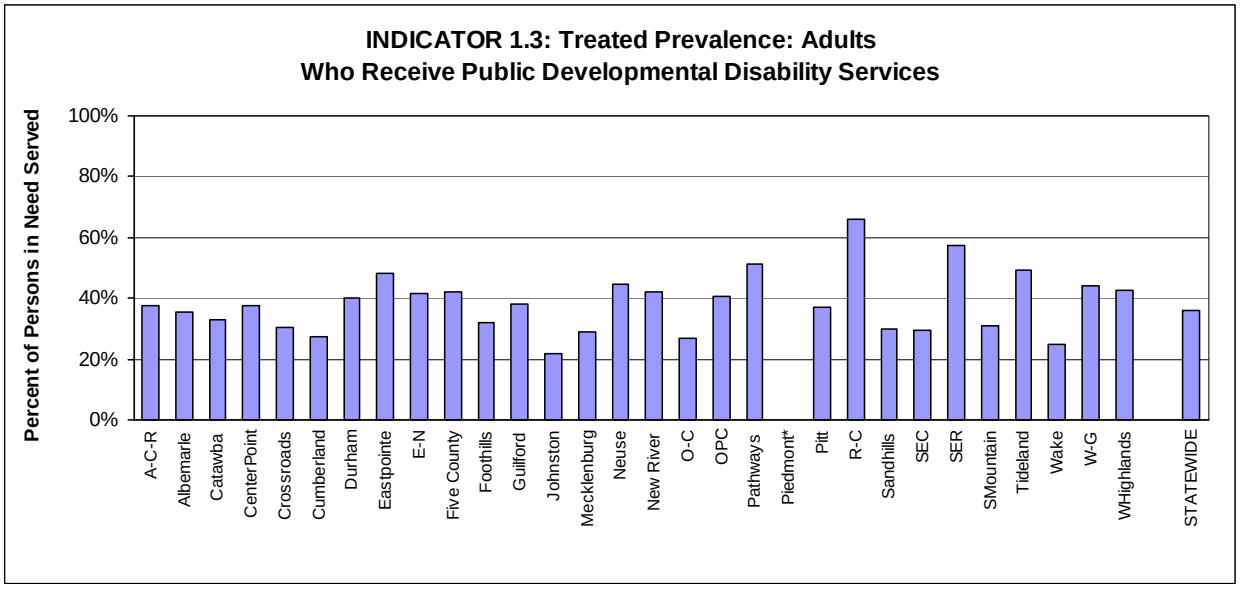
** Data on service claims for Piedmont are not available for this report.*

[8] URS Table 1: Number of Children with Serious Emotional Disturbances [*sic*], age 9 to 17, by State, 2005, Level of functioning score=60, midpoint of range between lower and upper limits of estimates. Prepared by NRI/SDICC for CMHS: August 29, 2006. The Division applies the estimates established by CMHS for children ages 9-17 to those under the age of 9, since no established estimates exist for younger children. Estimates adjusted to North Carolina population.

[9] The numbers served reflect children and adolescents, ages 3-17, who received any MH services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private funds. The NC Division of Public Health is responsible for all services from birth through age 2.

Indicator 1: Services to Persons in Need
1.3 Adult Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. January 1, 2006 - December 31, 2006; N=48,971 adults in need

Approximately eight out of every 1,000 adults (0.79%) in North Carolina have a developmental disability that requires supportive services.[10] Statewide, 17,651 adults (36% of those in need of services) received federal or state funded DD services through our community service system from January through December 2006.[11] The rate of adults who were served varied among LMEs from a low of 22% (Johnston) to a high of 66% (Roanoke-Chowan).

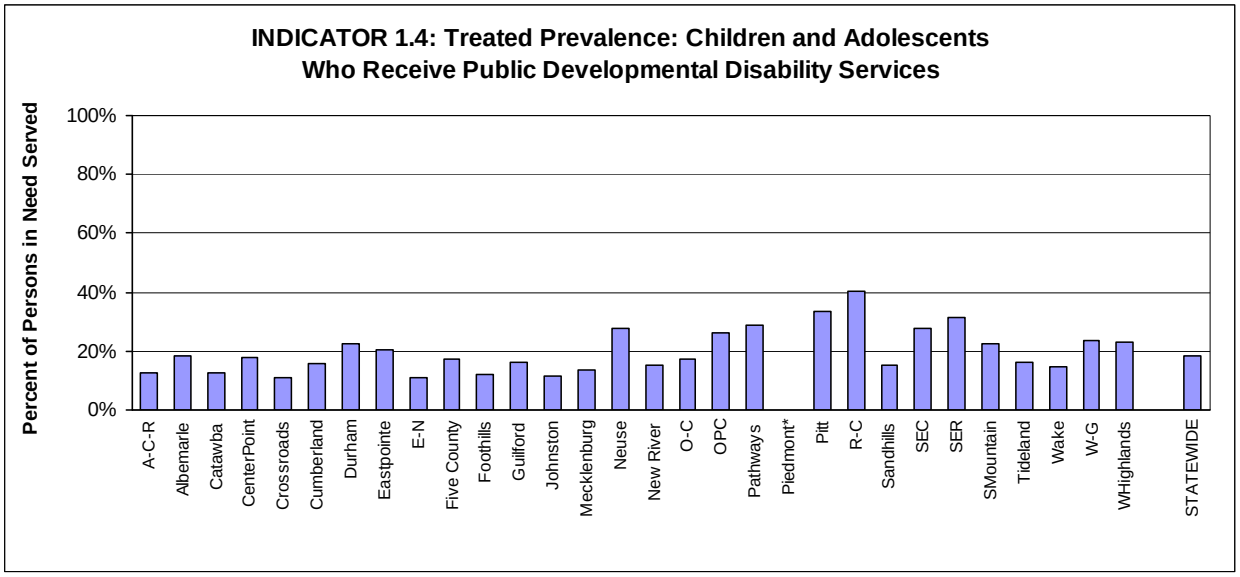
** Data on service claims for Piedmont are not available for this report.*

[10] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Estimates adjusted to North Carolina population.

[11] The numbers served reflect adults, ages 18 and over, who received any DD services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

Indicator 1: Services to Persons in Need
1.4 Child and Adolescent Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. January 1, 2006 - December 31, 2006; N=52,526 children and adolescents in need

Approximately thirty-two out of every 1,000 children and adolescents (3.21%) in North Carolina have a developmental disability that requires supportive services.[12] Statewide, 9,739 children and adolescents (19% of those in need of services) received federal or state funded DD services through our community service system from January through December 2006.[13] [14] The rate of those who were served varied among LMEs from a low of 11% (Crossroads and Edgecombe-Nash) to a high of 40% (Roanoke-Chowan).

** Data on service claims for Piedmont are not available for this report.*

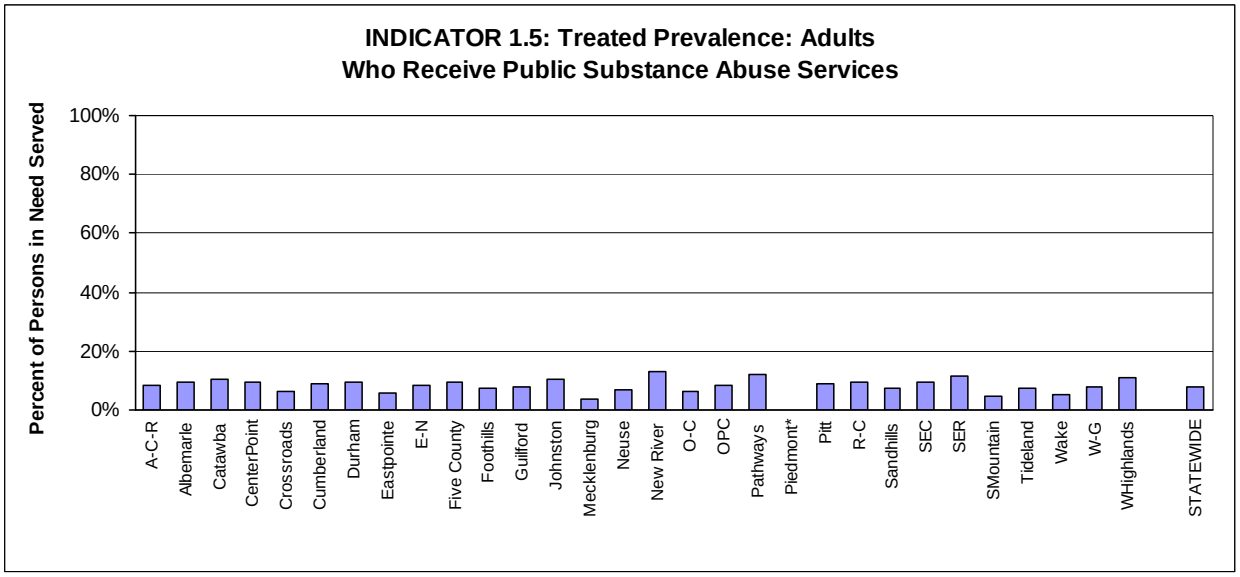
[12] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Estimates adjusted to North Carolina population.

[13] The numbers reflect children and adolescents, ages 3-17, who received any DD services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

[14] The NC Division of Public Health is responsible for all services from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21.

Indicator 1: Services to Persons in Need
1.5 Adult Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. January 1, 2006 - December 30, 2006; N=494,665 adults in need

Almost eighty out of every 1,000 adults (7.98%) in North Carolina experience a serious substance abuse problem in any given year.[15] Statewide, 39,476 adults (8% of those in need of services) received federal or state funded SA services through our community service system from January through December 2006.[16] The rate of adults who were served varied among LMEs from a low of 4% (Mecklenburg) to a high of 13% (New River).

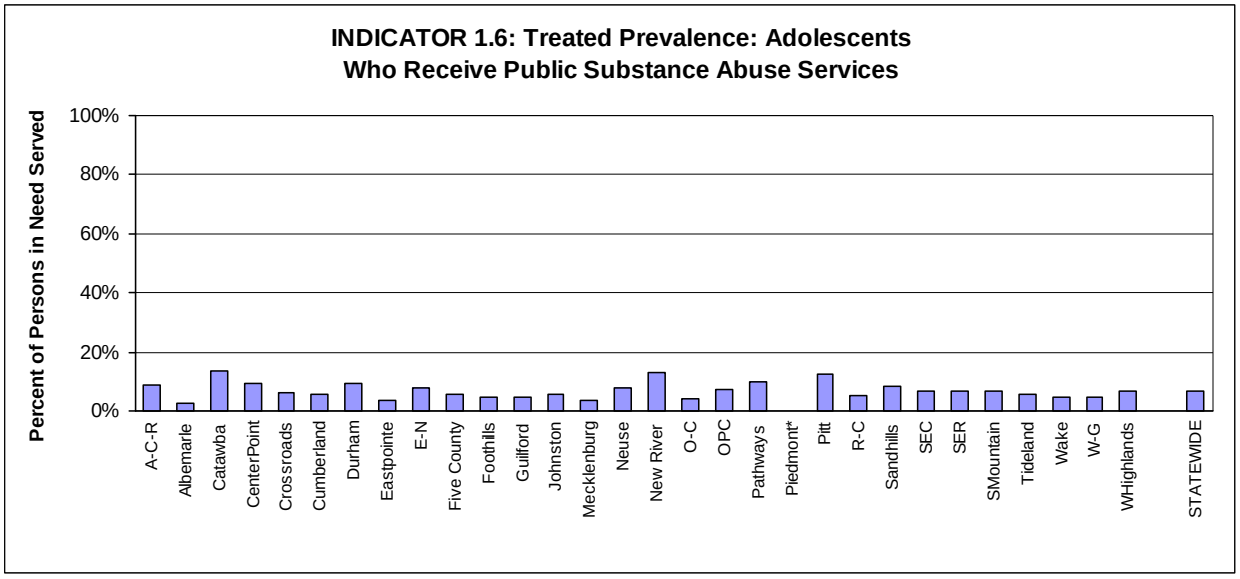
** Data on service claims for Piedmont are not available for this report.*

[15] *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health*, Table B.20, http://oas.samhsa.gov/nsduh.htm. Estimates adjusted to North Carolina population.

[16] The numbers served reflect adults, ages 18 and over, who received any SA services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

Indicator 1: Services to Persons in Need
1.6 Adolescent Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the ***prevalence***, or percent of the population estimated to have a particular condition in a given year, to the ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. January 1, 2006 - December 31, 2006; N=47,673 adolescents in need

A little more than seventy out of every 1,000 adolescents (7.24% of those ages 12-17) in North Carolina experience a serious substance abuse problem in any given year.[17] Statewide, 3,132 adolescents (7% of those in need of services) received federal or state funded services through our community service system from January through December 2006.[18] The rate of targeted adolescents who were served varied among LMEs from a low of 3% (Albemarle and Eastpointe) to a high of 14% (Catawba).

** Data on service claims for Piedmont are not available for this report.*

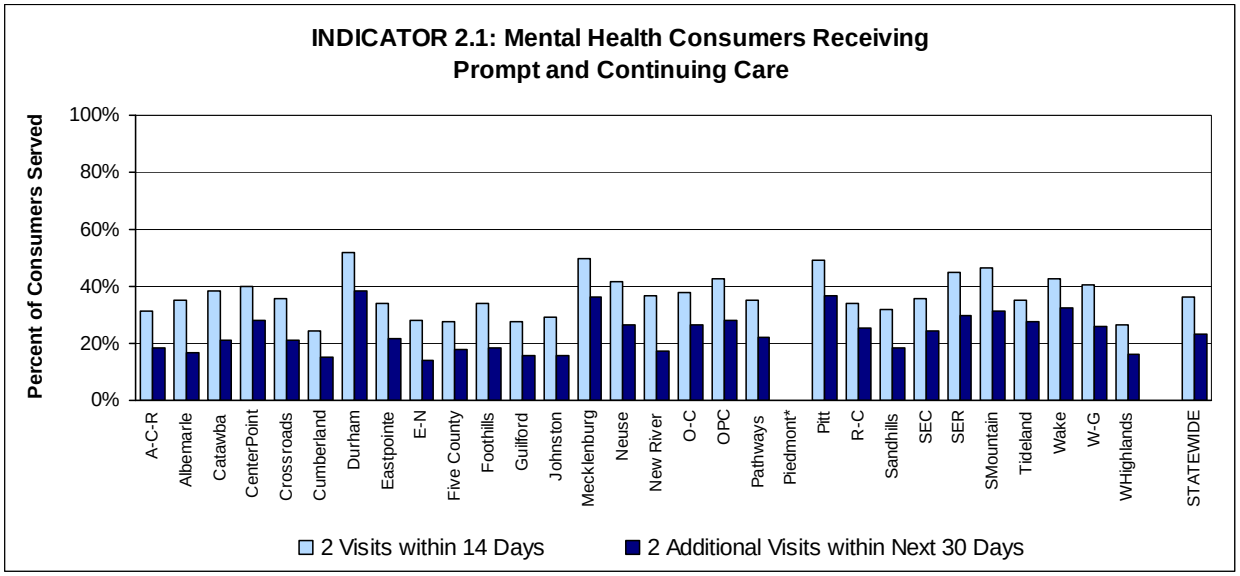
[17] *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health*, Table B.20, http://oas.samhsa.gov/nsduh.htm. Estimates adjusted to North Carolina population.

[18] The numbers served reflect adolescents, ages 12-17, who received any SA services (including assessments) in the community system, regardless of diagnosis, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving SA prevention services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, other federal, state, and local agencies, and private sources.

Indicator 2: Timely Initiation and Engagement in Service

2.1 Mental Health Services

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2006 (first service received); N=44,677 consumers

Thirty-six percent (36%) of NC residents (all age groups) who receive mental health services have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 25% (Cumberland) to a high of 52% (Durham). Compared to the other disability groups, consumers with mental illness wait longer on average for initiation of care.

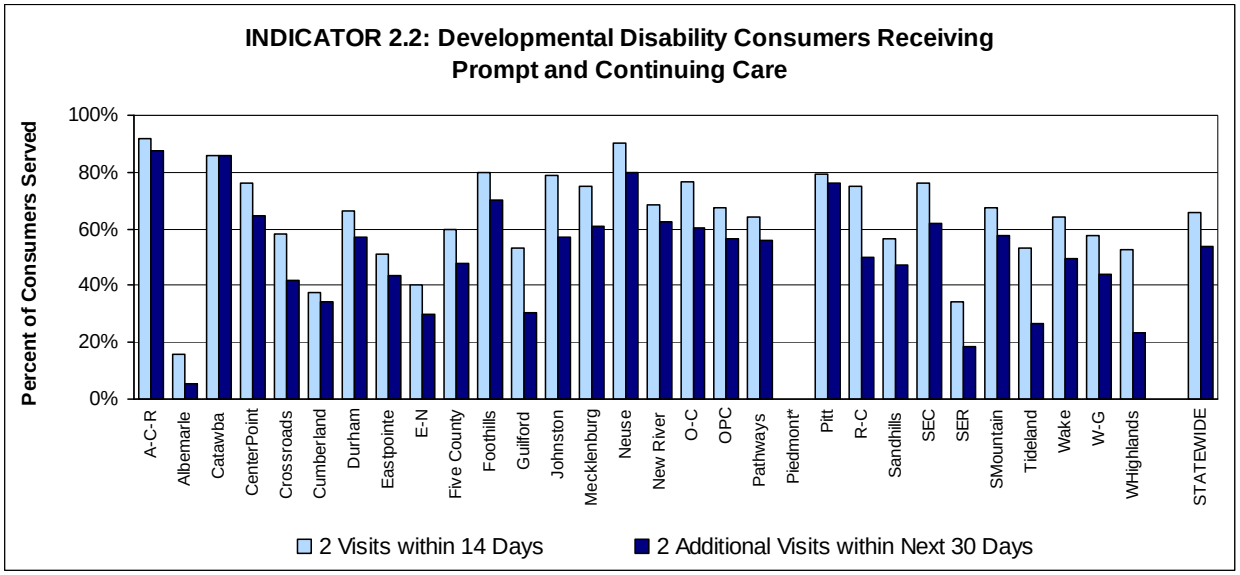
Just under one-fourth (23%) of mental health consumers have an additional two visits within the next 30 days, making a total of four visits in the first 45 days (a best practice for full engagement in care). Among LMEs, engagement ranged from a low of 14% (Edgecombe-Nash) to a high of 38% (Durham).

** Data on service claims for Piedmont are not available for this report.*

Indicator 2: Timely Initiation and Engagement in Service

2.2 Developmental Disability Services

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2006 (first service received); N=1,233 consumers

About two-thirds (66%) of NC residents (all age groups) who receive developmental disability services/supports have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 16% (Albemarle) to a high of 92% (Alamance-Caswell-Rockingham).

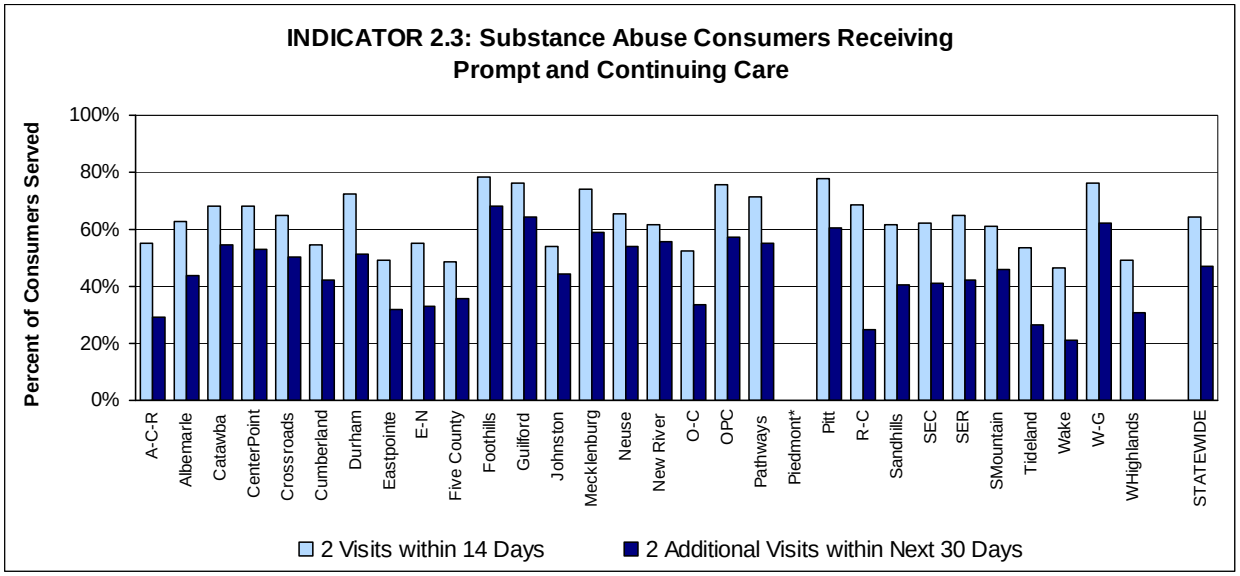
Over half (54%) of developmental disability consumers have an additional two visits within 30 days, making a total of four visits in the first 45 days (a best practice for full engagement in care). Among LMEs, engagement ranged from a low of 5% (Albemarle) to a high of 88% (Alamance-Caswell-Rockingham).

** Data on service claims for Piedmont are not available for this report.*

Indicator 2: Timely Initiation and Engagement in Service

2.3 Substance Abuse Services

Rationale: National standards[19] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. July 1 - September 30, 2006 (first service received); N=4,610 consumers

Close to two-thirds (64%) of NC residents (all age groups) who receive substance abuse services have two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranges from a low of 47% (Wake) to a high of 79% (Foothills).

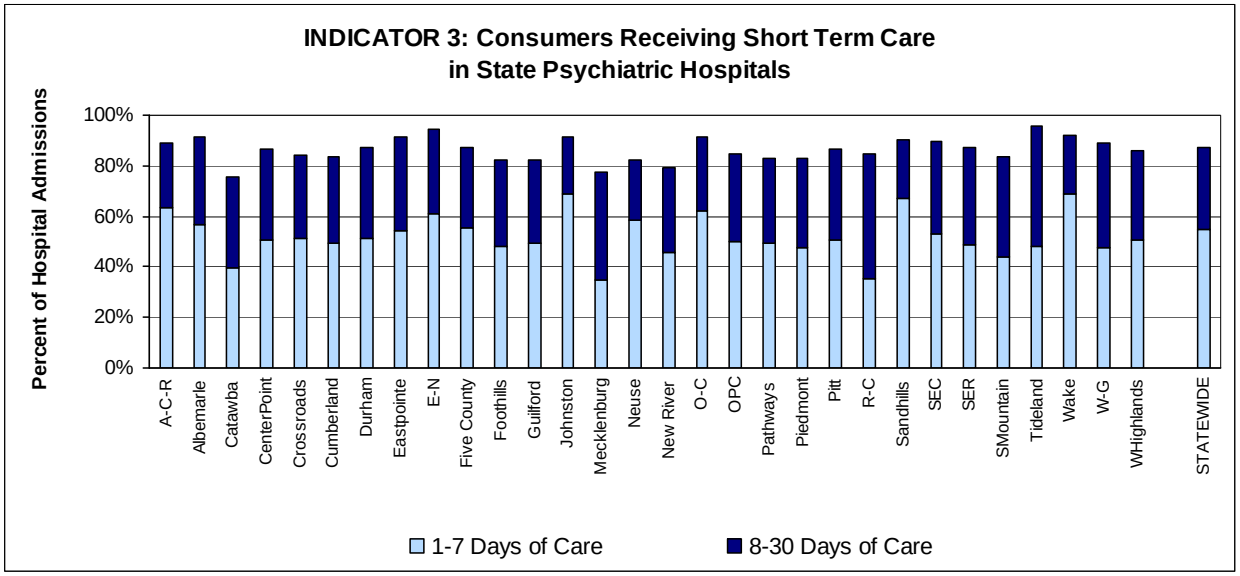
Almost half (47%) of substance abuse consumers have an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for full engagement in care). Among LMEs, engagement ranged from a low of 21% (Wake) to a high of 68% (Foothills).

** Data on service claims for Piedmont are not available for this report.*

[19] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 3: Effective Use of State Psychiatric Hospitals

Rationale: State psychiatric hospitals provide a safety net for the community service system. An adequate community system can and should provide their residents with crisis services and short-term inpatient care close to home. This helps families stay in touch and reserves high-cost state facility beds for consumers with long-term care needs. Reducing the short-term use of state psychiatric hospitals is a goal that also allows more effective and efficient use of funds for community services.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for discharges during October 1, 2006 - March 31, 2007; N=8,205 discharges

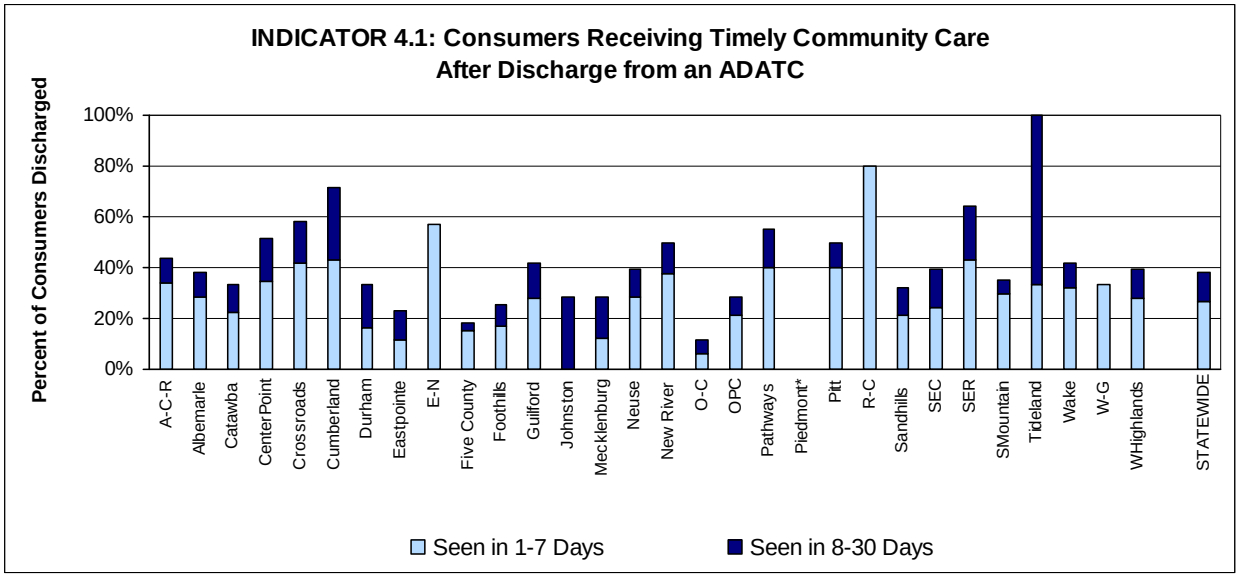
Of the statewide hospital discharges from October 2006 through March 2007, over half (55%) were hospitalized for 1-7 days (total number of statewide hospital stays for 1-7 days was 4,524) and 32% were hospitalized for 8-30 days (total number of statewide hospital stays for 8-30 days was 2,650). Lengths of stay of 1-7 days varied by LME from a high of 69% (Johnston and Wake) to a low of 35% (Mecklenburg). Johnston, Sandhills and Wake had the lowest rates for lengths of stay of 8-30 days (with 23%) while Roanoke-Chowan had a high of 49%.

Eighty-seven percent of NC's discharges from state psychiatric hospitals in the period of October 1, 2006 to March 31, 2007 were for stays of 30 days or less. *As local capacity to provide crisis services increases, the Division expects the number of short-term stays in state psychiatric hospitals to decrease.*

Indicator 4: Timely Follow-Up after Inpatient Care

4.1 ADATCs

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[20]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges July 1 - September 30, 2006); Medicaid and State Service Claims Data (for claims submitted July 1 - March 31, 2007); N=785 discharges

Statewide just over one-fourth (27%) of consumers discharged from an ADATC received follow-up care in the community within 7 days. An additional 12% of NC consumers were seen within 8-30 days of discharge.

Among LMEs, the percent of consumers receiving follow-up care within 7 days varied from a low of 0% (Johnston) to a high of 80% (Roanoke-Chowan). Overall, the percent of consumers receiving follow-up care within 1-30 days varied from a low of 12% (Onslow-Carteret) to a high of 100% (Tideland).

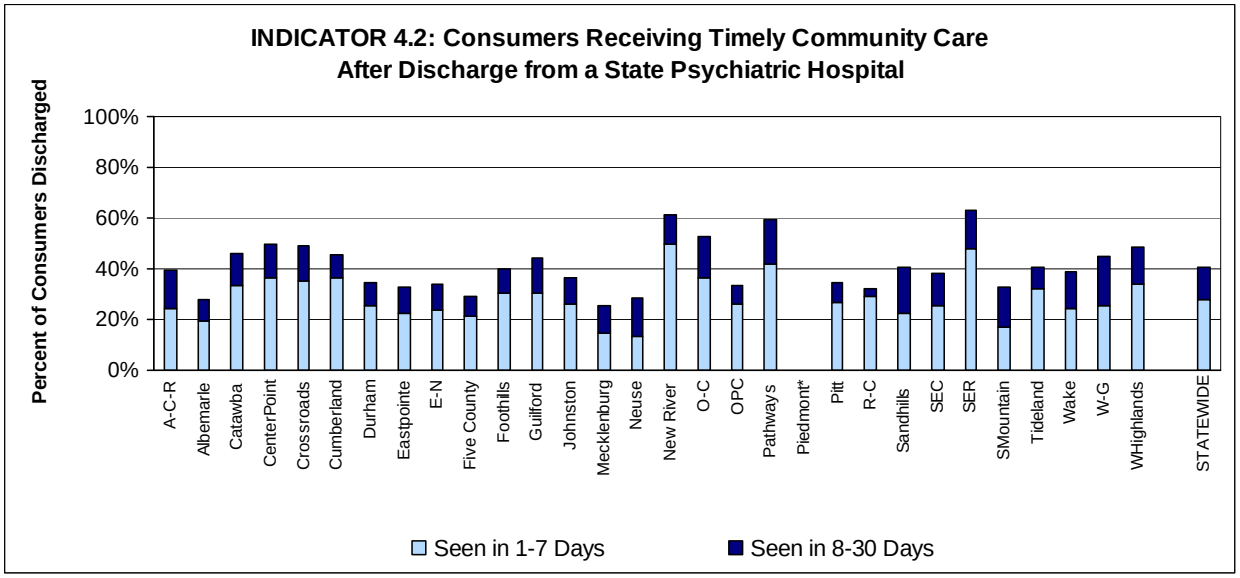
** Data on service claims for Piedmont are not available for this report.*

[20] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.

Indicator 4: Timely Follow-Up after Inpatient Care

4.2 State Psychiatric Hospitals

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[21]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges July 1 - September 30, 2006); Medicaid and State Service Claims Data (for claims submitted July 1 - March 31, 2007); N=4,438 discharges

Statewide, timely follow-up care from state psychiatric hospitals was very similar to that of ADATCs. Approximately 28% of consumers discharged from state psychiatric hospitals received follow-up care in the community within 7 days. An additional 13% of NC consumers were seen within 8-30 days of discharge.

Among LMEs, the percent of consumers receiving follow-up care within 7 days varied from a low of 13% (Neuse) to a high of 50% (New River). Overall, the percent of consumers receiving follow-up care within 1-30 days varied from a low of 25% (Mecklenburg) to a high of 63% (Southeastern Regional).

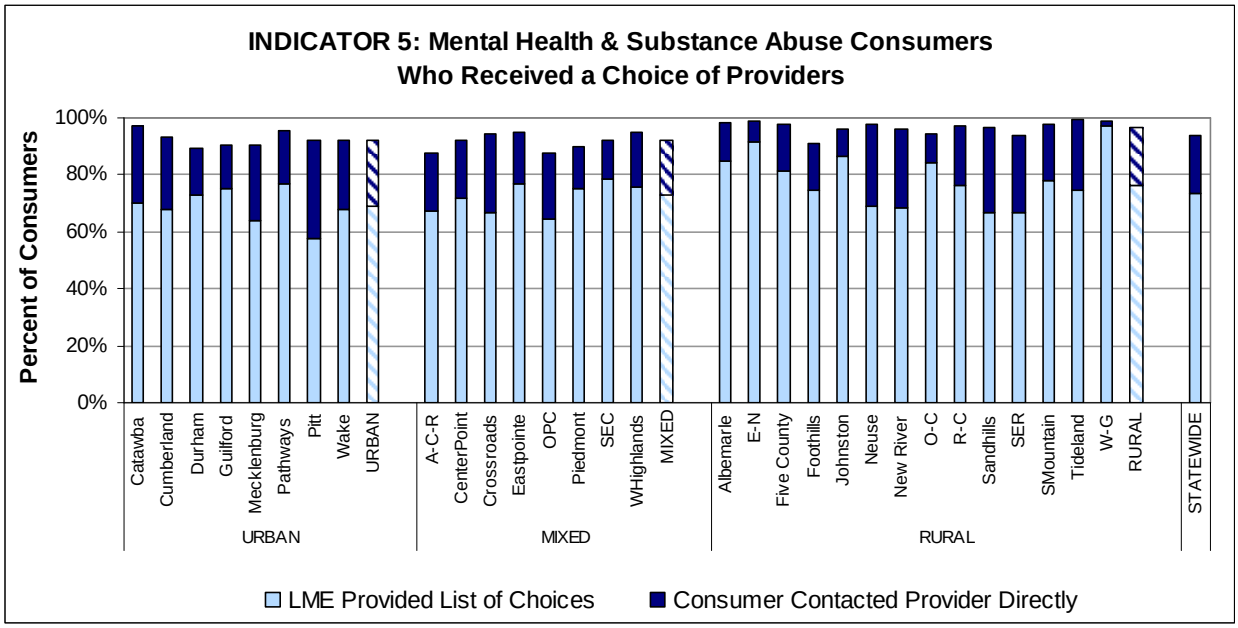
** Data on service claims for Piedmont are not available for this report.*

[21] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.

Service Quality

Indicator 5: Consumer Choice of Service Providers

Rationale: A system that offers consumers an array of providers supports the development of successful practitioner-consumer relationships which, in turn, foster recovery and stability. Consumer choice can also improve the quality of the entire service system, as providers strive to satisfy consumers.



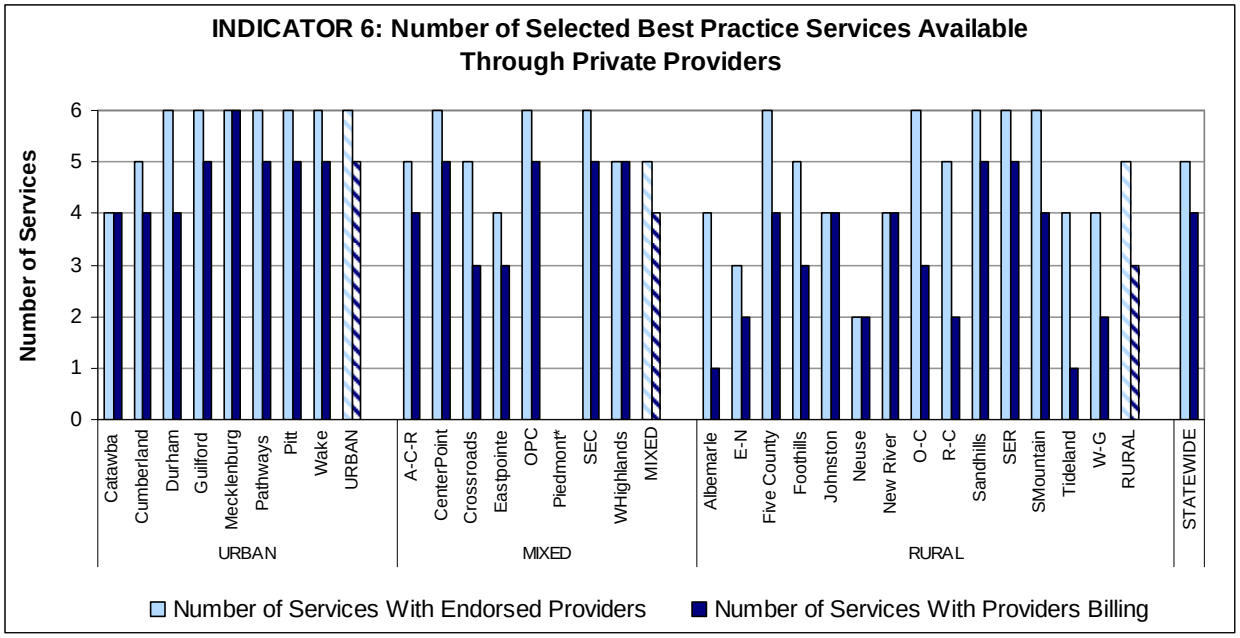
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. January 1 - March 31, 2007; N=16,555 Initial Interviews

Almost three-fourths (73%) of MH and SA consumers reported receiving options of places to receive services.[22] An additional 21% reported they contacted the provider directly. Among LMEs, the percent of consumers who were offered a list of options or who went directly to a provider varied from a low of 87% (Alamance-Caswell-Rockingham and Orange-Person-Chatham) to a high of 99% (Edgecombe-Nash, Tideland, and Wilson-Greene).

[22] The question in the Initial NC-TOPPS Interview reads: "Did you receive a list of options, verbal or written, of places to receive services?" Response options include "Yes, I received a list," "No, I came here on my own," and "No, I did not receive a list." Appropriate NC-TOPPS questions for DD consumers are currently being developed.

Indicator 6: Use of Evidence-Based Service Models and Best Practices

Rationale: Quality care is care that makes a real difference in an individual's life. Service models and practices that have been tested for effectiveness provide the greatest opportunity for individuals to attain stability in their lives. NC is promoting adoption of evidence-based practices and best practices in community service systems.



SOURCE: Medicaid Provider Endorsement Data and Medicaid Claims Data. April 1, 2006 - March 31, 2007; N=2,291 Endorsed Providers

North Carolina has endorsed almost 2,300 private provider agencies (other than LMEs) across the state to offer six services that are based on best practice models:

- Multi-systemic therapy (MST)**
- Assertive community treatment team (ACTT)**
- Community support/community support team (CS/CST)
- Intensive in-home (IIH)
- Substance abuse intensive outpatient program (SAIOP)
- Substance abuse comprehensive outpatient treatment (SACOT).

All six services are endorsed in fourteen LMEs, although only Mecklenburg has agencies that are currently providing all of them. Ten LMEs have agencies currently providing five of these services and eight LMEs have agencies providing four of these services.

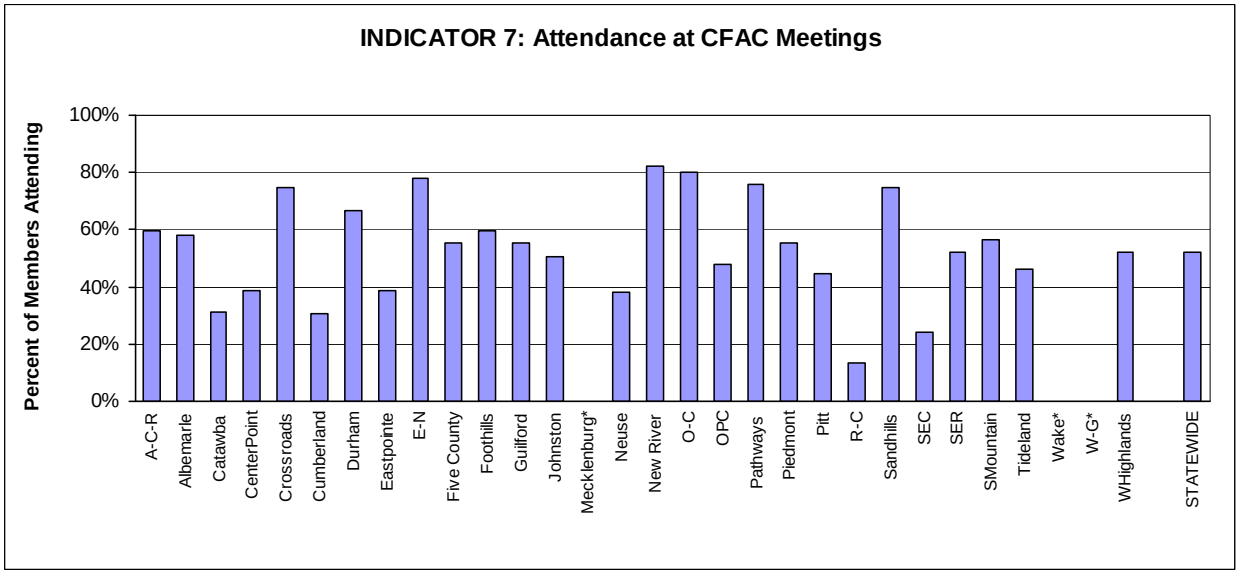
** Data on service claims for Piedmont are not available for this report.*

*** Multi-systemic therapy (MST) and assertive community treatment team (ACTT) are evidence-based practices.*

System Management

Indicator 7: Involvement of Consumers and Family Members in the Local System

Rationale: The vibrancy of the local Consumer and Family Advisory Committees (CFACs) provides an indication of the responsiveness of the local system and its effectiveness in meeting the needs of residents and consumers. An engaged CFAC membership, with balanced representation across disabilities, is necessary for the LME to hear and respond to the needs of its community.



SOURCE: Local CFAC meeting minutes. January 1 - March 31, 2007

Local Consumer and Family Advisory Committees (CFACs) are composed of consumers and family members representing each of the MH/DD/SA disabilities. CFACs in 24 LMEs met monthly during the quarter. The remaining CFACs met two times during the quarter. Statewide, the expected membership ranges from 9 in Guilford to 30 in OPC. Across the state, an average of 52% of expected members attended scheduled meetings.[23] Roanoke-Chowan had the lowest average of expected attendance (13% of 12 potential members) and New River had the highest (82% of 14 potential members).

** Edgecombe-Nash and Wilson-Greene share one CFAC and are reported under Edgecombe-Nash. Mecklenburg and Wake have not set an expected number of members. Mecklenburg averaged 11 members attending and Wake averaged 7 members attending.*

[23] Numbers in attendance include only appointed members.

Indicator 8: Effective Management of Service Funds

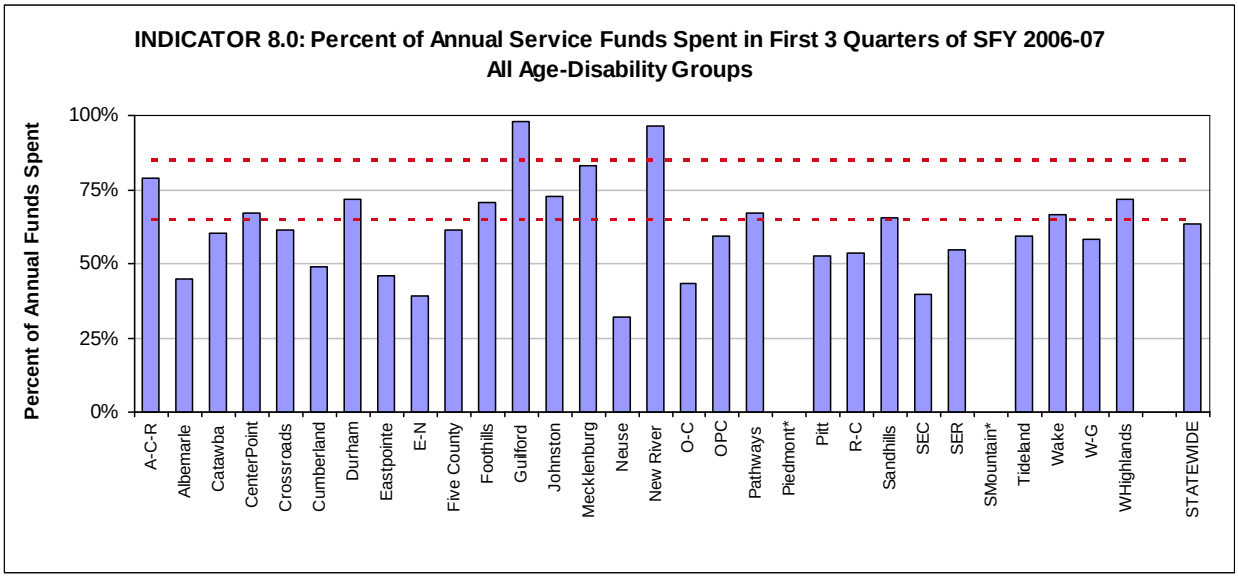
8.0 All Disability Groups

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

LME use of state and federal (non-Medicaid) funds can be affected by several factors, including[24]:

- the availability and use of local funds
- the proportion of the local population receiving Medicaid services
- local claims submission practices

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1, 2006 - March 31, 2007;
Total Budgeted UCR Funds=$257,571,687

Expenditures are expected to be between 65% and 85% at the end of the third quarter (indicated by the dotted red lines). Across all disabilities, LMEs spent approximately 63% of their LME-managed service funds during the first three quarters of SFY 2006-07.[25] Expenditures vary from a low of 32% (Neuse) to a high of 98% (Guilford). Funds expended vary much more by age-disability group.

** Service claims data for Piedmont and Smoky Mountain are not available for this report.*

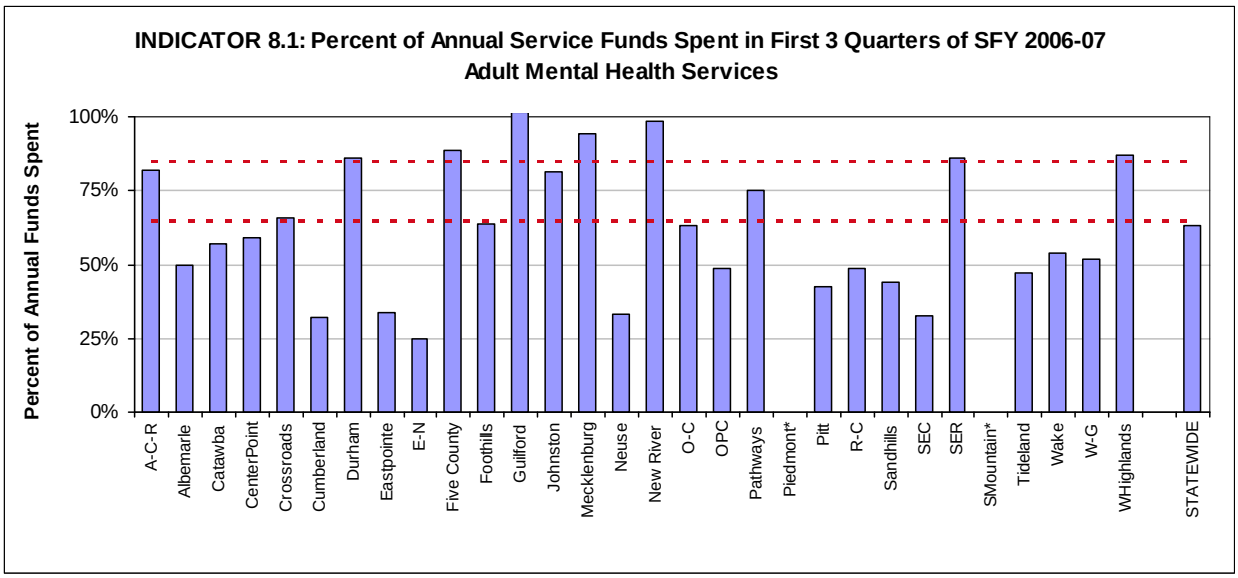
[24] In SFY 2006-07 LMEs are allowed to shift up to 15% of State-allocated funds between age-disability groups.

[25] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since the last report.

Indicator 8: Effective Management of Service Funds
8.1 Adult Mental Health Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1, 2006 - March 31, 2007;
Total Budgeted UCR Funds= $51,867,272

Expenditures are expected to be between 65% and 85% at the end of the third quarter (indicated by the dotted red lines). In SFY 2006-07, 63% of LME-managed funds for adult mental health services were expended in the first three quarters of this fiscal year.[26] The percent of funds spent varied across LMEs from a low of 25% (Edgecombe-Nash) to a high of 101% (Guilford).

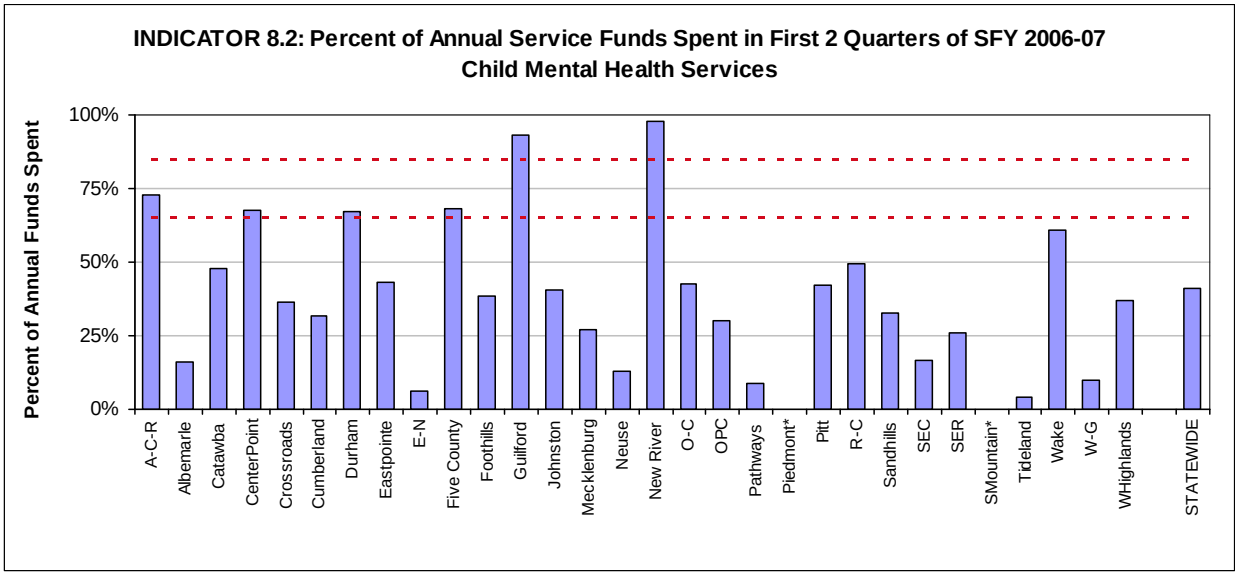
** Service claims data for Piedmont and Smoky Mountain are not available for this report.*

[26] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since the last report.

Indicator 8: Effective Management of Service Funds
8.2 Child Mental Health Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1, 2006 - March 31, 2007;
Total Budgeted UCR Funds= $36,517,128

Expenditures are expected to be between 65% and 85% at the end of the third quarter (indicated by the dotted red lines). Approximately 41% of SFY 2006-07 LME-managed funds for child mental health services were expended in the first three quarters of this fiscal year.[27] The percent of funds spent varied greatly across LMEs from a low of 4% (Tideland) to a high of 98% (New River).

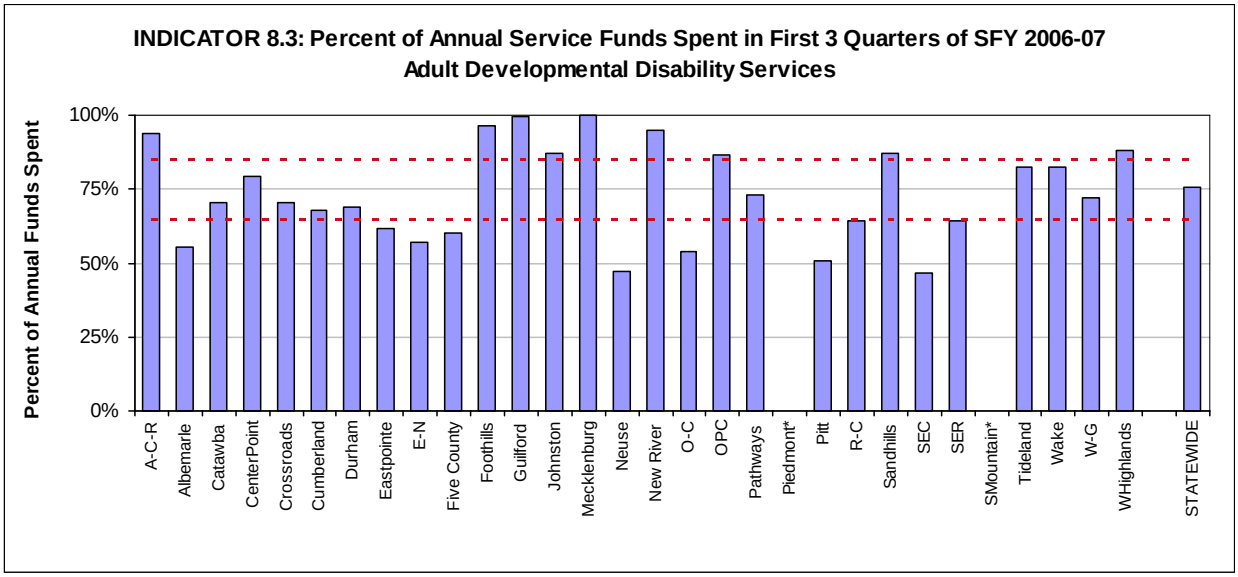
** Service claims data for Piedmont and Smoky Mountain are not available for this report.*

[27] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since the last report.

Indicator 8: Effective Management of Service Funds
8.3 Adult Developmental Disability Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1, 2006 - March 31, 2007;
Total Budgeted UCR Funds= $116,290,186

Expenditures are expected to be between 65% and 85% at the end of the third quarter (indicated by the dotted red lines). Approximately three-fourths (76%) of SFY 2006-07 LME-managed funds for adult developmental disability services were expended in the first three quarters of this fiscal year.[28] The percent of funds spent varied across LMEs from a low of 47% (Neuse and Southeastern Center) to a high of 100% (Mecklenburg).

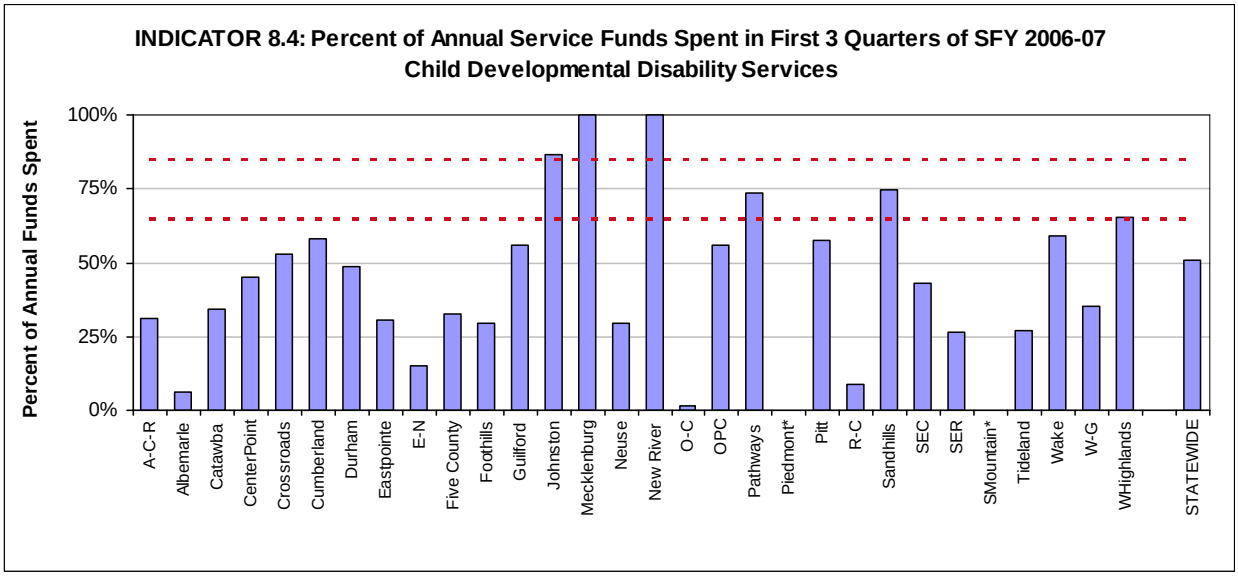
** Service claims data for Piedmont and Smoky Mountain are not available for this report.*

[28] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since the last report.

Indicator 8: Effective Management of Service Funds
8.4 Child Developmental Disability Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1, 2006 - March 31, 2007;
Total Budgeted UCR Funds= $17,767,745

Expenditures are expected to be between 65% and 85% at the end of the third quarter (indicated by the dotted red lines). Approximately half (51%) of SFY 2006-07 LME-managed funds for child developmental disability services were expended in the first three quarters of this fiscal year.[29] Funds varied greatly across LMEs with a low of 2% (Onslow-Carteret) to a high of 100% (Mecklenburg and New River).

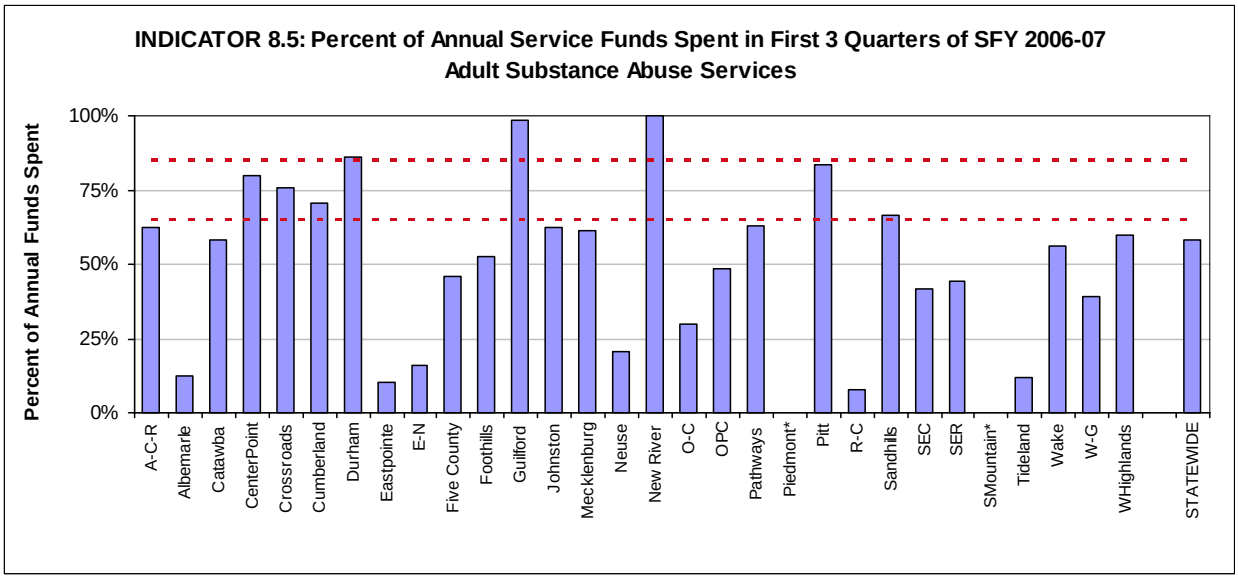
** Service claims data for Piedmont and Smoky Mountain are not available for this report.*

[29] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since the last report.

Indicator 8: Effective Management of Service Funds
8.5 Adult Substance Abuse Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1, 2006 - March 31, 2007;
Total Budgeted UCR Funds= $29,683,001

Expenditures are expected to be between 65% and 85% at the end of the third quarter (indicated by the dotted red lines). Approximately 58% of SFY 2006-07 LME-managed funds for adult substance abuse services were expended in the first three quarters of this fiscal year.[30] The percent of funds spent varied across LMEs from a low of 8% (Roanoke-Chowan) to a high of 100% (New River).

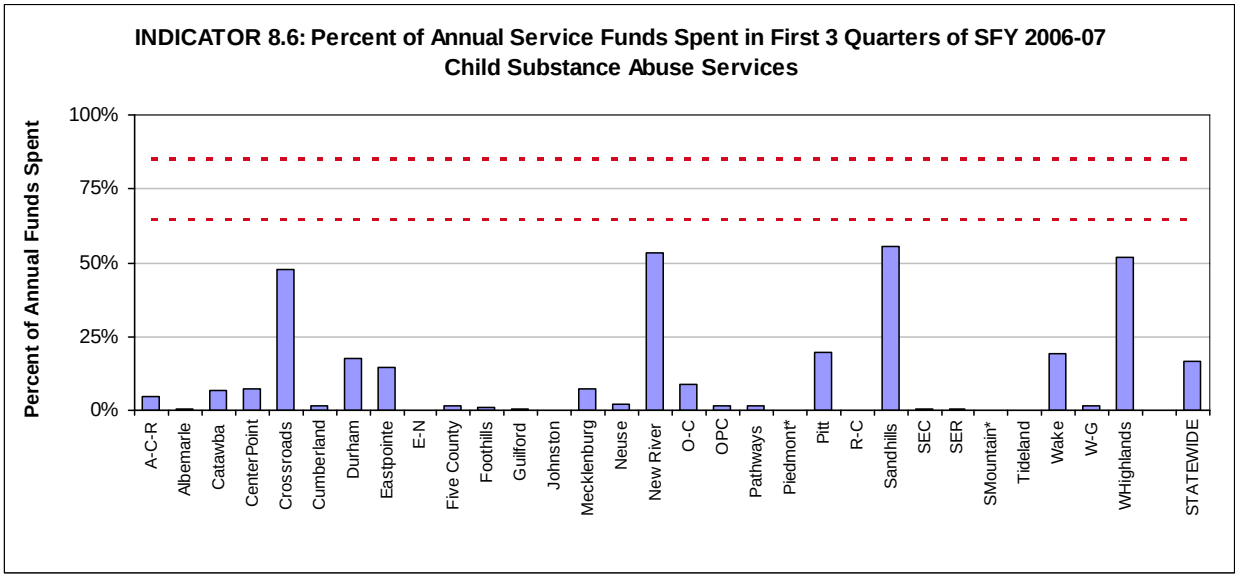
** Service claims data for Piedmont and Smoky Mountain are not available for this report.*

[30] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since the last report.

Indicator 8: Effective Management of Service Funds
8.6 Child Substance Abuse Services

Rationale: Appropriating using limited resources to serve the ongoing MH/DD/SAS needs of the community is a challenge for every LME. Planning for the use of funding across the entire year, while reaching the intended recipients of those funds, provides an indication of an LME's fiscal management performance and its activities to reach underserved groups.

Future reports will provide cumulative information on funds spent to-date in the fiscal year.



SOURCE: Service Claims Data for State and non-Medicaid Federal Funds. July 1, 2006 - March 31, 2007;
Total Budgeted Funds= $5,446,355

Expenditures are expected to be between 65% and 85% at the end of the third quarter (indicated by the dotted red lines). Only 17% of SFY 2006-07 LME-managed funds for child substance abuse services were expended in the first three quarters of this fiscal year, by far the lowest expenditures for any age-disability group.[31] Five of the LMEs spent no State funds on children with substance abuse service needs (Edgecombe-Nash, Johnston, Roanoke-Chowan, Southeastern Center, and Tideland). Of the remaining LMEs, 11 spent less than 5% of their funds for child substance abuse services. Sandhills Center, with the greatest expenditures, spent 56% of their funds.

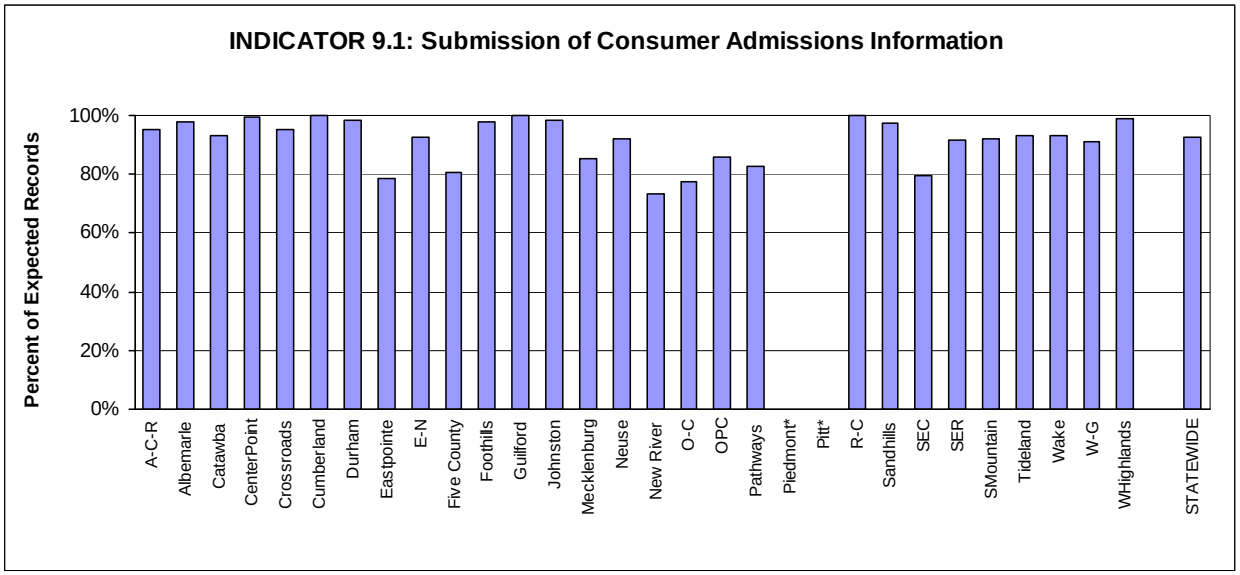
** Service claims data for Piedmont and Smoky Mountain are not available for this report.*

[31] The numbers exclude funds allocated or processed outside of IPRS. Budgets have been updated to reflect change in allocations since the last report.

Indicator 9: Effective Management of Information

9.1 Consumer Admissions

Rationale: Efficient flow of information is vital for effective decision making and oversight of a complex service system. Timely submission of consumer information is a gauge of the management and coordination capacity of the local system and the technological resources available to support it.



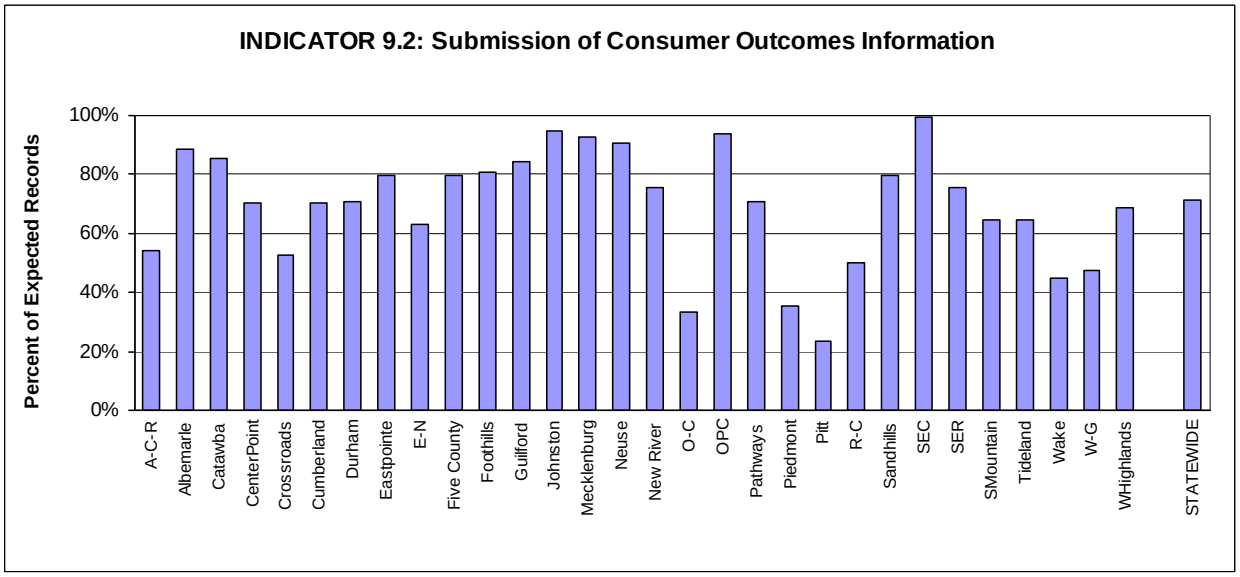
SOURCE: Consumer Data Warehouse Data. October 2006 - March 2007; State Service Claims Data (for claims submitted October 2006 - March 2007 for services provided October - December 2006). N=27,032 records received

Statewide, identification and demographic information was submitted on 94% of consumers that received a State-funded service during the prior quarter (October 1 - December 31, 2006). Submissions varied among LMEs from a low of 71% (New River) to a high of 100% by five LMEs (CenterPoint, Cumberland, Guilford, Johnston, and Western Highlands).

** Admissions data for Pitt are reported under Neuse. Piedmont data are not available for this report.*

Indicator 9: Effective Management of Information
9.2 Consumer Outcomes

Rationale: Efficient flow of information is vital for effective decision making and oversight of a complex service system. Timely submission of consumer information is a gauge of the management and coordination capacity of the local system and the technological resources available to support it.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data (for Initial Interviews July – September 2006). Updates received July 1, 2006 - March 31, 2007; N=13,592 expected updates

Statewide, NC-TOPPS Update Interviews (due after 90 days of service) were submitted for 71% of MH/SA consumers who had an Initial Interview between July and September 2006. The percent of expected Update Interviews submitted varied among LMEs from a low of 23% (Pitt) to a high of 100% (Southeastern Center).

The MH/DD/SAS Community Systems Progress Indicators Report and the Report Appendix are published four times a year. Both are available on the Division's website:
http://www.ncdhhs.gov/mhddsas/statspublications/reports/

Questions and feedback should be directed to:
NC DMH/DD/SAS Quality Management Team
ContactDMHQuality@ncmail.net
(919/733-0696)